AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

❶ PATIENT NAME:

PRINT name of patient (Last, First, MI)	Date of Birth

❷ CURRENT OR FORWARDING ADDRESS AND TELEPHONE:

____

Street Address City State Zip code Phone

❸ I AUTHORIZE THE RELEASE OF MEDICAL RECORDS FROM:

- ❑ 111 Hundertmark Road, Suite 420 • Chaska, MN 55318 • 952-448-3847 • Fax: 952-448-5083
- ❑ 916 St. Peter Avenue, Suite 120 • Delano, MN 55328 • 763-230-2780 • Fax: 763-972-2230
- ❑ 9325 Upland Lane North, Suite 111 • Maple Grove, MN 55369 • 763-324-8000 • Fax: 952-473-7908
- ❑ 14001 Ridgedale Drive, Suite 100 • Minnetonka, MN 55305 • 952-473-0211 • Fax: 952-473-7908
- ❑ 4695 Shoreline Drive, Suite A • Spring Park, MN 55384 • 952-495-8910 • Fax: 952-471-2585

❹ PLEASE RELEASE MY PROTECTED HEALTH INFORMATION (PHI) TO:

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Clinic or Individual's Name Phone Fax

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Street Address City State Zip code

❺ IN THE FORMAT SELECTED:

❑ Paper ❑ Email ❑ CD

❻ DATE INFORMATION NEEDED:______________________________________

➢ *Please choose:* ❑ Fax ❑ Mail ❑ Pick up ❑Email______________________________

❼ PURPOSE OF RELEASE (Check all that apply):

➢ Transfer of care due to:

- ❑ New primary care clinic
- ❑ 18+ or older/new primary clinic
- ❑ Out of town/state move
- ❑ Insurance change

➢ Non-transfer request:

- ❑ Consultation/Second Opinion
- ❑ Personal or school-related
- ❑ Legal *(charges apply)*
- ❑ Life Insurance application *(charges apply)*

❽ SPECIFIC INFORMATION REQUESTED:

- ❑ Vaccine records, ***no charge***
- ❑ Clinic visit notes, lab and x-ray results, medication list (***first release, most recent two years: no charge)***
- ❑ **All or additional records after most recent two years: $25.00 Flat Fee, payable in advance to Wayzata Children's Clinic.**
- ❑ Other, specific information only *(please explain)* ______________________________________
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❾ AUTHORIZATION:

I understand that Wayzata Children's Clinic, P.A. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form. I must sign in order to release my protected health information. This authorization is valid for information disclosed for purpose of treatment, payment and health care operations **for one year unless otherwise specified**. I understand that I can revoke this authorization at any time in writing. I understand that once information is released pursuant to this authorization, Wayzata Children's Clinic, P.A. cannot prevent the redisclosure of the information to another third party.

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Signature of Patient or Guardian Printed Name Relationship Date

(Patients 18 years or older are legally required to sign any/all authorizations)

Revised – 12/15/16